Exhibit 3 (Part 10)

AMI of Toms River
1430 Hooper Ave
Suite 102
Toms River, NJ 08753
(732) 349-2867

RADIOLOGY CONSULTATION REPORT (CONT)

IRVING STROUSE M.D.
279 3rd Ave
Ste 504
Long Branch, NJ 07740

Patient Name: RALPH VANDEVENTER
DOB [redacted] **MRN:** 237273 **E#:** E-00456807

Exam Completed:	November 13, 2008 11:37:00		
Dictated by:	MARY ANN PETERSON M.D.	Dictated Date:	November 13, 2008 11:44:16
Approved Date:	November 13, 2008 11:49:39	Print Date/Time:	November 18, 2008 08:34:29

Dictated by: MARY ANN PETERSON M.D.
Electronically signed by: MARY ANN PETERSON M.D.
Transcriptionist: HSIMOES
Transcribed Dt/Time: 11/13/08 11:49

Transcriber: HSIMOES
Transcription Date/Time: November 13, 2008 11:49:04

FAX

IRVING D. STROUSE, M.D., P.A.
279 Third Avenue, Suite 504
Long Branch, NJ 07740
Telephone: (732) 229-4333
Fax: (732) 571-1937

4695 Route 9
Howell, NJ 0
Telephone: (732) 370-
Fax: (732) 370-

WARNING

The information contained in this facsimile message is privileged and confidential. Information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately.

Please advise us of any difficulties in receiving this transmission by calling the numbers listed above.

TO:

Name Attn: Christina

Company Teta

FAX Number 518-880-6610

FROM:

Name

Date Time

TRANSMISSION

This cover letter plus 1 pages attached.

INFO

Re: Ralph Vandereratur

REPLY REQUIRED? **URGENT?**

EXCUSE SLIP

IRVING D. STROUSE, M.D., P.A.
Diplomate American Board of Orthopedic Surgery
279 Third Avenue, Suite 504
Long Branch, New Jersey 07740
(732) 229-4333

Date: 11-13-08

To Whom It May Concern: Ralph Vandeventer is under my care.

He / She:

- ☐ Was seen in my office today for a necessary appointment.
- ☐ Please excuse or being tardy to: school work

DIAGNOSIS (FOR ALL MARKED SELECTIONS/BELOW): Left achilles tendon
Lumbar Sprain

- ☐ Please excuse for being absent from school / work on _____ to _____
- ☐ Is released to return to school on _____.
- ☒ Is released to return to work on 12-1-08.
  - ☐ Full Duty ☐ Light Duty
- ☐ Is / Is not able to participate in the physical education program at school.
- ☐ Is not able to participate in _____
- ☐ Surgery is scheduled for _____ and patient may return to school / work after _____ weeks.
  Type of surgery to be performed: _____
- ☐ RESTRICTIONS Remain out of work til 12-1-08
- ☐ OTHER: _____

(SIGNATURE)

FROM : A-Z VIDEO FAX NO. : 7322704287 Nov. 14 2008 12:42PM P1

To: Christina Tete # of pages 2
Fax: 518-880-6610 11/14/08

From: Ralph Van Deventer [redacted]

re: Case # 74518

Dear Christina,

Here is the doctor's excuse slip they gave me that was a result of last Monday's Dr. visit. Please include it in the file for your reference. Thanks for calling my employer and updating them on the new return to work date. If you have any questions, please call me.

Thanks again for your help.

Ralph

EXCUSE SLIP

IRVING D. STROUSE, M.D., P.A.
Diplomate American Board of Orthopedic Surgery
279 Third Avenue, Suite 504
Long Branch, New Jersey 07740
(732) 229-4333

Date: 11-13-08

To Whom It May Concern: Ralph Vandeventer is under my care.

He / She:

- ☐ Was seen in my office today for a necessary appointment.
- ☐ Please excuse for being tardy to: school work
- DIAGNOSIS (FOR ALL MARKED SELECTIONS BELOW): Left achilles tendon
  Lumbar Sprain
- ☐ Please excuse for being absent from school / work on _____ to _____
- ☐ Is released to return to school on _____
- ☒ Is released to return to work on 12-1-08
  Full Duty Light Duty
- ☐ Is / is not able to participate in the physical education program at school.
- ☐ Is not able to participate in _____
- ☐ Surgery is scheduled for _____ and patient may return to school / work after _____ weeks.
  Type of surgery to be performed: _____
- ☐ RESTRICTIONS: Remain out of work
  -Ed 12-1-08
- ☐ OTHER: _____

[SIGNATURE]

FAX

IRVING D. STROUSE, M.D., P.A.
279 Third Avenue, Suite 504
Long Branch, NJ 07740
Telephone: (732) 229-4333
Fax: (732) 571-1837

4695 Route 9 N
Howell, NJ 07
Telephone: (732) 370-4
Fax: (732) 370-1

WARNING

TO:

Name Att: Christina

Company Teta

FAX Number 518-880-6610

FROM:

Name

Date Time

TRANSMISSION

This cover letter plus 1 pages attached.

INFO

Re: Ralph Vanderenter

REPLY REQUIRED? **URGENT?**

RALPH VANDE /ENTER

DO[redacted]

11-10-08

HISTORY: Patient seems to be improved as far as his left Achilles tendon is concerned. The mass has decreased. The tenderness is less. He has continued with his walking boot. He still has significant lower back pain however. There is no change in his neurologic status, but he is complaining of increased left sciatica.

PLAN: For this reason, I am ordering an MRI of the lumbar spine to further delineate the pathology. For now, he will continue physical therapy.

RETURN: 1 month

IDS:pb

FAX

IRVING D. STROUSE, M.D., P.A.
279 Third Avenue, Suite 504
Long Branch, NJ 07740
Telephone: (732) 229-4333
Fax: (732) 571-1937

WARNING

TO:

Name Christina Testa

Company 6610

FAX Number 518-880-

FROM:

Name

Date Time

TRANSMISSION

This cover letter plus pages attached.

INFO

RE: Ralph VanDeventer
office note for
10-17-08, 11-10-08

REPLY REQUIRED? **URGENT?**

RALPH VANDEVENTER

DOB [redacted]

11-10-08

HISTORY: Patient seems to be improved as far as his left Achilles tendon is concerned. The mass has decreased. The tenderness is less. He has continued with his walking boot. He still has significant lower back pain however. There is no change in his neurologic status, but he is complaining of increased left sciatica.

PLAN: For this reason, I am ordering an MRI of the lumbar spine to further delineate the pathology. For now, he will continue physical therapy.

RETURN: 1 month

IDS:pb

FROM : A-Z VIDEO FAX NO. : 7322704287 Oct. 21 2008 11:50AM P1

Fax to:
Reed Group
ATTN: Christina Teta
518-880-6610

10/21/08

# of pages = 2

From: Ralph Van Deventer
732- [redacted]
FAX: [redacted]

re: Case # 74578

Dear Christina,

I am faxing to you the script that Dr. Strause wrote for me on Friday to continue the P.T. I have also contacted his office to fax the needed information from Friday's appointment. I hope you get this today. If you don't there phone # is 732-229-4333.

Thank you!
Ralph Van Deventer

FROM : A-Z VIDEO FAX NO. : 7322704287 Oct. 21 2008 11:51AM P2

State of New Jersey
PRESCRIPTION BLANK

IRVING D. STROUSE, M.D.
279 THIRD AVENUE, SUITE 504
LONG BRANCH, NJ 07740
(732) 229-4333 FAX (732) 571-1937

DEA #AS 1444190
BATCH #HST080602000011 NPI #1184715963 LIC #25MA02268

PATIENT Ralph Vandevenlen D.O.B.
ADDRESS DATE 10/21/08

Rx

Continue PT
3 x wk Ca 3 wks

SUBSTITUTION PERMISSIBLE DO NOT SUBSTITUTE
SIGNATURE OF PRESCRIBER
DO NOT REFILL
REFILL TIMES

Use separate form for each controlled substance prescription

received on 10/21/2008 11:10:19 AM [Eastern Daylight Time]

FAX

IRVING D. STROUSE, M.D., P.A.
279 Third Avenue, Suite 504
Long Branch, NJ 07740
Telephone: (732) 229-4333
Fax: (732) 571-1937

WARNING

TO:

Name Christina Testa

Company 6610

FAX Number 518-880-[redacted]

FROM:

Name

Date Time

TRANSMISSION

This cover letter plus _____ pages attached.

INFO

RE: Ralph VanDeventer
office note for
10-17-08

REPLY REQUIRED? **URGENT?**

RALPH VANDEVENTER

DOB [redacted]

10-17-08

HISTORY: Patient is still having difficulty with both his lumbar spine and Achilles tendon. The Achilles tendon continues to demonstrate a mass, which is palpable and tender. His back still reveals some residual spasm but negative straight leg raising and no neurologic deficits.

PLAN: Continue physical therapy. Continue out of work.

RETURN: 1 month

IDS:pb

ReedGroup The Medical Disability Advisor

15 Tech Valley Drive
Suite 3, Second Floor
East Greenbush, NY 12061

October 27, 2008

Ralph Van Deventer, Jr.
[redacted]

Case #: 74518
WWID#: 10900

Dear Ralph Van Deventer, Jr.:

Johnson & Johnson has contracted with the Reed Group to review and monitor requests for Short Term Disability (STD) benefits.

Your request for STD benefits was received on 9/9/2008 for your absence beginning 9/8/2008. Based on your diagnosis and medical information submitted by your Health Care Provider, your STD benefits have been approved and extended through 11/16/2008. Reed Group will continue to review your claim on an ongoing basis to determine the potential for an earlier release to return to work, with or without temporary restrictions. Therefore, if is determined by Reed Group that you can return to work, in any capacity, prior to the last authorized date of our disability as indicated in this letter, you are expected to comply in order to continue receiving STD benefits. In the event that you and your health care provider determine that you can return to work prior to 11/17/2008, please contact us immediately to facilitate your return to work.

If you had previously been approved under the Family and Medical Leave Act (FMLA) and/or State Family Medical Leave (SFML) for this disability and you still have enough remaining days available, your FMLA and/or SFML approval will be extended. If you have exhausted your FMLA and/or SFML days, you will receive notification in a separate letter.

It is important to note that should you require an extension or will not return to work on or before the authorization end date, it is your responsibility to ensure that you and/or your health care provider submits additional objective medical documentation to Reed Group five (5) days prior to the last authorized date for review to extend STD benefits. Examples of this objective medical documentation are:

- Physician office/progress notes
- Diagnostic test results (X-rays, MRI, etc.)
- Laboratory results
- Physical Therapy notes
- Medical clearance from disability

Per the Company policy, if an employee does not return to work within three (3) business days of the end of the approved time off, the Company may determine that the employee has voluntarily resigned and consider the employee's employment to be terminated.

Please call 866-829-8861 if you have any questions or concerns.

Thank you,

Cristina Teta
Reed Group

ReedGroup
The Medical Disability Advisor

15 Tech Valley Drive
Suite 3, Second Floor
East Greenbush, NY 12061

October 7, 2008

Ralph Van Deventer Jr.
[redacted]

Case #: 74518
WWID#: 10900

Dear Ralph Van Deventer Jr.:

Johnson & Johnson has contracted with the Reed Group to review and monitor requests for Short Term Disability (STD) benefits.

Your request for STD benefits was received on 9/9/2008 for your absence beginning 9/8/2008. Based on your diagnosis and medical information submitted by your Health Care Provider, your STD benefits have been approved and extended through 10/26/2008. Reed Group will continue to review your claim on an ongoing basis to determine the potential for an earlier release to return to work, with or without temporary restrictions. Therefore, if is determined by Reed Group that you can return to work, in any capacity, prior to the last authorized date of our disability as indicated in this letter, you are expected to comply in order to continue receiving STD benefits. In the event that you and your health care provider determine that you can return to work prior to 10/27/2008, please contact us immediately to facilitate your return to work.

If you had previously been approved under the Family and Medical Leave Act (FMLA) and/or State Family Medical Leave (SFML) for this disability and you still have enough remaining days available, your FMLA and/or SFML approval will be extended. If you have exhausted your FMLA and/or SFML days, you will receive notification in a separate letter.

It is important to note that should you require an extension or will not return to work on or before the authorization end date, it is your responsibility to ensure that you and/or your health care provider submits additional objective medical documentation to Reed Group five (5) days prior to the last authorized date for review to extend STD benefits. Examples of this objective medical documentation are:

- Physician office/progress notes
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- Laboratory results
- Physical Therapy notes
- Medical clearance from disability

Per the Company policy, if an employee does not return to work within three (3) business days of the end of the approved time off, the Company may determine that the employee has voluntarily resigned and consider the employee's employment to be terminated.

Please call 866-829-8861 if you have any questions or concerns.

Thank you,

Cristina Teta
Reed Group

15 Tech Valley Drive
Suite 3, Second Floor
East Greenbush, NY 12061

FROM : A-Z VIDEO FAX NO. : 7322704287 Oct. 03 2008 12:38PM P1

10/3/08

To: Christina Teta
Reed Group
Fax: 518-880-6610

# of pages: 3

From: Ralph Van Deventer
[redacted]

Re: Case # 74518 (List of Medications)

To Christina,

Please find attached a list of medications that have been prescribed to me as a result of my disability. I have also written a list of medications (info taken from the bottle) in case the script is illegible. Any questions, please call me.

Thanks,

Ralph Van Deventer

FROM : A-Z VIDEO FAX NO. : 7322704287 Oct. 03 2008 12:38PM P2

received on 10/3/2008 11:58:46 AM [Eastern Daylight Time]

74518 State of New Jersey

PRESCRIPTION BLANK

PRONTO MED-CARE
FRANK P. MATTEACE, M.D.
567 FISCHER BOULEVARD
TOMS RIVER, NJ 08753-6275

506-6869
H # MDI-20060405-IM5016536-17

LIC. # MA046372
DEA # BM 0477706

IF PRESCRIPTION IS WRITTEN AT ALTERNATE PRACTICE SITE, CHECK HERE ☐
AND PRINT ALTERNATE ADDRESS AND TELEPHONE NUMBER ON REVERSE SIDE

[PAT]IENT Ralph Van Nelenten Jr D.O.B. ______

[AD]DRESS ______ DATE 9/30/08

Rx

Dx Achilles tendonosis
Low Back Pain

meds: Flexeril 10 TID 8/26
Naprosyn 500 BID

Xanax 10 OD
Clonopin .5 BID
Physical ty 3x/wk

Soma 350 TID
Mobic 15 OD 9/12
Vicodin 7.5 C° PRN

[SUB]STITUTION PERMISSIBLE ______ DO NOT SUBSTITUTE ______

[D]O NOT REFILL ______
[REF]ILL ______ TIMES

SIGNATURE OF PRESCRIBER [signature]

Use separate form for each controlled substance prescription

UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PUNISHABLE BY LA[W]

FROM : A-Z VIDEO FAX NO. : 7322704287 Oct. 03 2008 12:38PM P3

Case# 74518

8/26

Cyclobenzaprim 10mg 3x daily (muscle relaxer)

Naproxen 500mg 2x daily (inflamation)

9/12

Carisorpold 350mg 3x daily (muscle relaxer)

Meloxicam 15mg 1x daily (inflamation)

Hydrocordone/APAP 5/500mg 1/6hrs (pain)

~~Lexapro~~ 10mg 1x daily (depression)

Klonopin 0.5mg 2x daily (anxiety)

P.T. 3X/wk

Reed group Attn Christine fax#
518-880-6600
Dr. Struzz to fax a progress report

received on 10/3/2008 11:58:46 AM [Eastern Daylight Time]

FROM : A-Z VIDEO FAX NO. : 7322704287 Oct. 03 2008 12:35PM P1

10/3/08

To: Christina Teta
Reed Group
Fax: 518-880-6610

# of pages: 3

From: Ralph Van Deventer
[redacted]

Re: Case # 74518 (List of Medications)

To Christina,

Please find attached a list of medications that have been prescribed to me as a result of my disability. I have also written a list of medications (info taken from the bottle) in case the script is illegible. Any questions, please call me.

Thanks,

Ralph VanDeventer

received on 10/3/2008 11:56:32 AM [Eastern Daylight Time]

74518 State of New Jersey

PRESCRIPTION BLANK

PRONTO MED-CARE
FRANK P. MATTEACE, M.D.
567 FISCHER BOULEVARD
TOMS RIVER, NJ 08753-8275
506-6869
LIC. # MA048072
DEA # BM 0477706

H # MDI-20060405-IM6016536-17

IF PRESCRIPTION IS WRITTEN AT ALTERNATE PRACTICE SITE, CHECK HERE ☐
AND PRINT ALTERNATE ADDRESS AND TELEPHONE NUMBER ON REVERSE SIDE

PATIENT Ralph Van Nelunten Jr D.O.B. _____

ADDRESS _____ DATE 9/30/08

Rx

Dx Achilles tendonosis
Low Back Pain

meds: Flexeril 10 TID 9/16
Naprosyn 500 BID
Soma 350 TID
Xanax 1.0 QD
clonop. 2.5 BID
Imitrex 15 QD 9/16
physical ty 3x/wk Vicodin 7.5 Q6° PRN

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____

DO NOT REFILL _____ SIGNATURE OF PRESCRIBER

FILL _____ TIMES

Use separate form for each controlled substance prescription

UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY ARE CRIMES PUNISHABLE BY U.S.

ReedGroup www.rgl.net The Medical Disability Advisor

AUTHORIZATION TO DISCLOSE AND USE MEDICAL INFORMATION FOR DISABILITY-RELATED DETERMINATIONS

Claimant's Full Name Ralph R. VanDeventer Jr. Date of Birth: [redacted]

Employer's Name: Johnson & Johnson Social Security Number (last 4 digits only): xxx-xx- 5069

I authorize all doctors, hospitals, other health care providers, government agencies, insurers, employers, schools, training facilities, health plans, policyholders, contract holders, vendors, health and benefit plan administrators or their successors ("Records Holders") to give out my medical information as explained on this form.

This information includes, but is not limited to, any records or facts about my medical condition, treatment, supplies, expenses, coverage or benefits, or my employment, vocation, education, training, or income, relating to my current disability or my ability to work, whether obtained prior to or after the date of this authorization ("Information").

Information may be provided to the following individuals or entities ("Benefit Managers"): the employer named above, Reed Group, their benefit plan or claims administrator(s), their related companies, contractors, investigators, attorneys, and service consultants, health care providers who treat or evaluate me with respect to my claim, and other individuals or entities involved in administering, evaluating, analyzing and managing the plan or my claim, to allow them to evaluate, analyze, manage and/or administer my claim for short term disability benefits, long term disability benefits, salary continuation, leave under the federal Family and Medical Leave Act, local and state leave laws, workers' compensation and/or any other health benefit program or leave benefit offered by and through my employer ("Benefits Program"), to support, defend, or review any determinations made with respect to the programs and benefits and to give my Information to any other person or entity if needed to find out whether I am eligible for benefits, to manage my claim under a Benefits Program, or to run a Benefits Program. The Benefits Managers will tell those receiving the Information that the Information is confidential.

I understand that once my Information is given out as authorized in this form, federal privacy laws may not protect it. Benefits Managers may give Information out again as described in this form.

I understand that this permission lasts twelve (12) months after my claim and all appeals are processed or twelve (12) months after the end of my coverage or benefits under the Benefits Program, whichever is longer, unless the law requires a shorter period. If I change my mind before that time, I can tell Reed Group in writing that I do not want Record Holders or Benefit Managers to share any more information. If I write to stop them from sharing information, it will not change any actions they took before they receive my letter.

If I do not sign this form, it will not affect how my health care providers treat me. However, if I do not sign, the Benefits Managers may not be able to review my claim and find out whether I am eligible for benefits. This may result in the delay or denial of my request for benefits.

The Information released under this authorization can be sent electronically, by phone or fax, or by mail. I know I can see or request a copy of the records given to the Benefits Managers. I agree that a copy of this form may be treated as a signed original. I understand the terms of this form.

Ralph R VanDeventer Jr. 9-29-08

Claimant's or Legal Representative's Signature Date

Legal Representative's Name (if any) Legal Representative's Relationship

The person or entity disclosing the Information is responsible for deciding whether to accept this authorization form and, on acceptance, shall send a copy to the claimant.

Please Fax to Reed Group at 518-880-6610 or return by mail in the enclosed business reply envelope

ReedGroup www.rgl.com

The Medical Disability Advisor

REIMBURSEMENT AGREEMENT
SHORT TERM DISABILITY PLAN

EMPLOYEE STATEMENT

Name:	Social Security Number:	Date of Birth:
Ralph Robert Van Deventer Jr.	[redacted]	[redacted]
Address - Street:	**City:** / **State:**	**Zip Code:**
965 Forge Lane	Toms River / NJ	08753
Home Telephone Number:	**Employee's Home E-mail Address** (if available):	
732-270-2897		

I am familiar with and understand the provisions of the Short Term Disability Plan for Eligible Employees of Johnson & Johnson and Affiliated Companies (the "Plan") that require that monthly payments to me will be reduced by certain amounts, such as state disability insurance (where applicable) and workers' compensation benefits. I understand that these reductions may sometimes be based on a reasonable estimate of the amount of other benefits that will be paid to me. I agree to these reductions.

I further understand and agree that I am required to repay Johnson & Johnson for any overpayments that have been made to me, including, without limitation, payments that have not been offset (or offset fully) for retroactive awards of state disability insurance, workers' compensation or other relevant benefits, as described under the terms of the Plan, and that I am required to pay the Plan any amounts that I recover from a third party in connection with my disability to the extent provided under the terms of the Plan. I agree to make these payments promptly, in accordance with the terms of the Plan. I understand and agree to the terms of the Plan regarding other rights of the Plan to recover amounts through subrogation and third party reimbursement.

I further agree to notify the Reed Group immediately upon my receiving notice that I have or will receive any amounts that offset my benefits under the Plan or any amounts that oblige me to pay or repay any amount to the Plan.

Employee's Signature:	Date:
Ralph R Van Deventer Jr	9/29/08
Witness Signature:	**Date:**
Maryanne VanDeventer	9/29/08

Please Fax to 518-880-6610 or Mail to the Address Listed Above

ReedGroup www.rgl.net

ATTENDING PHYSICIAN'S STATEMENT

NOTE TO PHYSICIAN OR OTHER HEALTH CARE PROVIDER: Your full completion of this form is necessary so that the employee's application for benefit may be received and processed. PLEASE ANSWER ALL QUESTIONS. RETURN FORM TO REED GROUP PROMPTLY to 15 Tech Valley Drive, 2nd Floor, Suite 3, East Greenbush, NY 12061. Fax (518) 880-6610.

Patient's Full Name: Ralph Robert Van Deventer Sr. | Date of birth: [redacted]

Date symptoms first appeared or accident happened? | Date patient first consulted you for this condition: 9-8-08

Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☒ No
If "Yes", please explain:

Is condition due to pregnancy? ☐ Yes ☐ No
If "Yes", expected date of delivery: _____

Primary Diagnosis: Tenosynovitis of Ankle | Primary ICD Code (if available): 727.06

Secondary diagnosis: Lumbar Sprain | Secondary ICD Code (if available): 847.2

Treatment Plan: detail the complete treatment plan (including therapy or referrals to other specialists):
Cam Walker for left ankle. Physical therapy for back

State the surgical, obstetrical, or other diagnostic or therapeutic procedures requires, if any (Describe fully):
Procedure: _____

Date(s) Performed: _____ ☐ Inpatient ☐ Outpatient

Hospital Name: _____ Admission Date: _____ Discharge Date: _____

Medications: List all prescribed medications including Name, Dose, Frequency, and Start Date

Office Visits: Date of Last Visit 9-29-08 Date of Next Scheduled Visit: ~~10-13-08~~ 10-17-08

Functional Status: Has Patient been totally unable to work?
☒ Yes, From: 9-8-08 Through: _____
☐ No

What are the Functional Limitations that currently prevent the patient from working in any capacity?

Estimated Return to Work Date: 10/27/08
Modified Hours and/or duty date: _____
Full hours/duty date: _____

State any restrictions and/or accommodations which may be needed for modified duty and duration thereof:

Name of referring physician (if applicable): | Referring physician's telephone number:

Address - Street: | City: | State: | Zip Code:

Physician's full name/Specialty (please print): IRVING D. STROUSE, M.D., P.A. | Physician's telephone number: 732-229-4333

Address - Street: 279 3rd Ave #504 | City: Long Branch | State: NJ | Zip Code: 07740

Attending physician's signature: | Date: 9/25/08

Reed Group | 15 Tech Valley Drive | 2nd Floor, Suite 3 | East Greenbush, New York 12061 | 866-829-8861 | Fax: 518-880-6610

State of New Jersey
PRESCRIPTION BLANK

IRVING D. STROUSE, M.D.
279 THIRD AVENUE, SUITE 504
LONG BRANCH, NJ 07740
(732) 229-4333 FAX (732) 571-1937

DEA #AS1444180 LIC #25MA 0226880
BATCH #HST080602000011 NPI #1184715963 SERIAL # 00103

IF PRESCRIPTION IS WRITTEN AT ALTERNATE PRACTICE SITE, CHECK HERE ☐
AND PRINT ALTERNATE ADDRESS AND TELEPHONE NUMBER OR PRIVATE USE

PATIENT Ralph Van Deventer D.O.B.

ADDRESS DATE 9/25/08

Rx

Continue PT
3x wk for 3 wks

SUBSTITUTION PERMISSIBLE DO NOT SUBSTITUTE

DO NOT REFILL SIGNATURE OF PRESCRIBER

REFILL TIMES

Use separate form for each controlled substance prescription

ANY UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM, FICTITIOUS ALTERATIONS OR FORGERY, ARE CRIMES PUNISHABLE BY

ReedGroup www.rgl.net

AUTHORIZATION TO DISCLOSE AND USE MEDICAL INFORMATION FOR DISABILITY-RELATED DETERMINATIONS

Claimant's Full Name Ralph R. VanDeventer Jr. Date of Birth: [redacted]

Employer's Name: Johnson & Johnson Social Security Number (last 4 digits only): xxx-xx- 5069

I authorize all doctors, hospitals, other health care providers, government agencies, insurers, employers, schools, training facilities, health plans, policyholders, contract holders, vendors, health and benefit plan administrators or their successors ("Records Holders") to give out my medical information as explained on this form.

This information includes, but is not limited to, any records or facts about my medical condition, treatment, supplies, expenses, coverage or benefits, or my employment, vocation, education, training, or income, relating to my current disability or my ability to work, whether obtained prior to or after the date of this authorization ("Information").

Information may be provided to the following individuals or entities ("Benefit Managers"): the employer named above, Reed Group, their benefit plan or claims administrator(s), their related companies, contractors, investigators, attorneys, and service consultants, health care providers who treat or evaluate me with respect to my claim, and other individuals or entities involved in administering, evaluating, analyzing and managing the plan or my claim, to allow them to evaluate, analyze, manage and/or administer my claim for short term disability benefits, long term disability benefits, salary continuation, leave under the federal Family and Medical Leave Act, local and state leave laws, workers' compensation and/or any other health benefit program or leave benefit offered by and through my employer ("Benefits Program"), to support, defend, or review any determinations made with respect to the programs and benefits and to give my Information to any other person or entity if needed to find out whether I am eligible for benefits, to manage my claim under a Benefits Program, or to run a Benefits Program. The Benefits Managers will tell those receiving the Information that the Information is confidential.

I understand that once my Information is given out as authorized in this form, federal privacy laws may not protect it. Benefits Managers may give Information out again as described in this form.

I understand that this permission lasts twelve (12) months after my claim and all appeals are processed or twelve (12) months after the end of my coverage or benefits under the Benefits Program, whichever is longer, unless the law requires a shorter period. If I change my mind before that time, I can tell Reed Group in writing that I do not want Record Holders or Benefit Managers to share any more information. If I write to stop them from sharing Information, it will not change any actions they took before they receive my letter.

If I do not sign this form, it will not affect how my health care providers treat me. However, if I do not sign, the Benefits Managers may not be able to review my claim and find out whether I am eligible for benefits. This may result in the delay or denial of my request for benefits.

The Information released under this authorization can be sent electronically, by phone or fax, or by mail. I know I can see or request a copy of the records given to the Benefits Managers. I agree that a copy of this form may be treated as a signed original. I understand the terms of this form.

Ralph R VanDeventer Jr. 9-29-08

Claimant's or Legal Representative's Signature Date

Legal Representative's Name (if any) Legal Representative's Relationship

The person or entity disclosing the Information is responsible for deciding whether to accept this authorization form and, on acceptance, shall send a copy to the claimant.

Please Fax to Reed Group at 518-880-6610 or return by mail in the enclosed business reply envelope

ReedGroup www.rgl.com | The Medical Disability Advisor

REIMBURSEMENT AGREEMENT
SHORT TERM DISABILITY PLAN

EMPLOYEE STATEMENT

Name:	Social Security Number:	Date of Birth:
Ralph Robert Van Deventer Jr.	[redacted]	[redacted]
Address - Street:	**City:** / **State:**	**Zip Code:**
905 Forge Lane	Toms River / NJ	08753
Home Telephone Number:	**Employee's Home E-mail Address (if available):**	
732-270-2897		

I am familiar with and understand the provisions of the Short Term Disability Plan for Eligible Employees of Johnson & Johnson and Affiliated Companies (the "Plan") that require that monthly payments to me will be reduced by certain amounts, such as state disability insurance (where applicable) and workers' compensation benefits. I understand that these reductions may sometimes be based on a reasonable estimate of the amount of other benefits that will be paid to me. I agree to these reductions.

I further understand and agree that I am required to repay Johnson & Johnson for any overpayments that have been made to me, including, without limitation, payments that have not been offset (or offset fully) for retroactive awards of state disability insurance, workers' compensation or other relevant benefits, as described under the terms of the Plan, and that I am required to pay the Plan any amounts that I recover from a third party in connection with my disability to the extent provided under the terms of the Plan. I agree to make these payments promptly, in accordance with the terms of the Plan. I understand and agree to the terms of the Plan regarding other rights of the Plan to recover amounts through subrogation and third party reimbursement.

I further agree to notify the Reed Group immediately upon my receiving notice that I have or will receive any amounts that offset my benefits under the Plan or any amounts that oblige me to pay or repay any amount to the Plan.

Employee's Signature:	Date:
Ralph R Van Deventer Jr	9/29/08
Witness Signature:	**Date:**
Marianne Van Deventer	9/29/08

Please Fax to 518-880-6610 or Mail to the Address Listed Above

ReedGroup www.rgl.net

ATTENDING PHYSICIAN'S STATEMENT

NOTE TO PHYSICIAN OR OTHER HEALTH CARE PROVIDER: Your full completion of this form is necessary so that the employee's application for benefit may be received and processed. PLEASE ANSWER ALL QUESTIONS. RETURN FORM TO REED GROUP PROMPTLY to 15 Tech Valley Drive, 2nd Floor, Suite 3, East Greenbush, NY 12061. Fax (518) 880-6610

Patient's Full Name: Ralph Robert Van Deventer Sr. | Date of birth: [redacted]

Date symptoms first appeared or accident happened? | Date patient first consulted you for this condition: 9-8-08

Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☒ No
If "Yes", please explain:

Is condition due to pregnancy? ☐ Yes ☐ No
If "Yes", expected date of delivery: _____

Primary Diagnosis: Tenosynovitis @ Ankle | Primary ICD Code (if available): 727.06

Secondary diagnosis: Lumbar Sprain | Secondary ICD Code (if available): 847.2

Treatment Plan: detail the complete treatment plan (including therapy or referrals to other specialists):
Cam Walker for left ankle. Physical Therapy for back

State the surgical, obstetrical, or other diagnostic or therapeutic procedures requires, if any (Describe fully)
Procedure: _____
Date(s) Performed: _____ ☐ Inpatient ☐ Outpatient

Hospital Name: _____ Admission Date: _____ Discharge Date: _____

Medications: List all prescribed medications including Name, Dose, Frequency, and Start Date

Office Visits: Date of Last Visit 9-29-08 Date of Next Scheduled Visit: ~~10-13-08~~ 10-17-08

Functional Status: Has Patient been totally unable to work?
☒ Yes, From: 9-8-08 Through: _____
☐ No

What are the Functional Limitations that currently prevent the patient from working in any capacity?

Estimated Return to Work Date: 10/27/08
Modified Hours and/or duty date: _____
Full hours/duty date: _____

State any restrictions and/or accommodations which may be needed for modified duty and duration thereof:

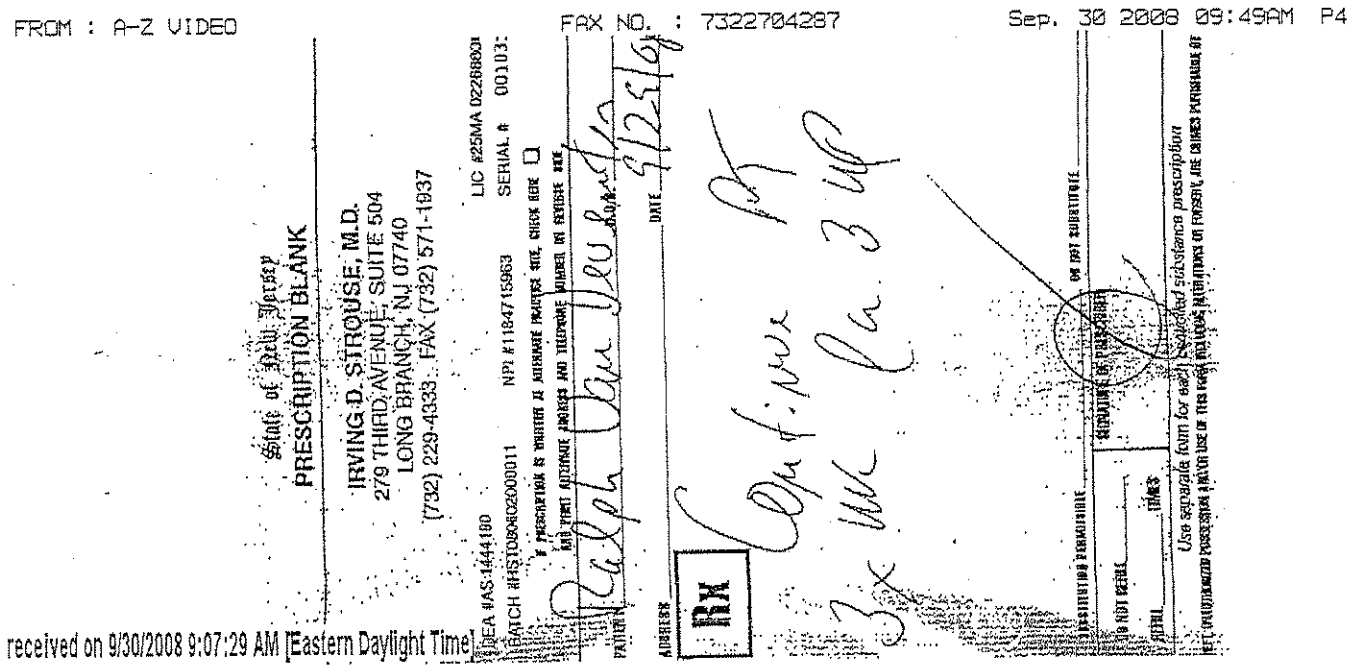
Name of referring physician (if applicable): | Referring physician's telephone number:

Address - Street: | City: | State: | Zip Code:

Physician's full name/Specialty (please print): IRVING D. STROUSE, M.D., P.A. | Physician's telephone number: 732-229-4333

Address - Street: 279 3rd Ave #504 | City: Long Branch | State: NJ | Zip Code: 07740

Attending physician's signature: [signature] | Date: 9/25/08



ReedGroup www.rgl.net The Medical Disability Advisor

AUTHORIZATION TO DISCLOSE AND USE MEDICAL INFORMATION FOR DISABILITY-RELATED DETERMINATIONS

Claimant's Full Name Ralph R. VanDeventer Jr. Date of Bir[redacted]

Employer's Name: Johnson & Johnson Social Security Number (last 4 digits only): xxx-xx- 5069

I authorize all doctors, hospitals, other health care providers, government agencies, insurers, employers, schools, training facilities, health plans, policyholders, contract holders, vendors, health and benefit plan administrators or their successors ("Records Holders") to give out my medical information as explained on this form.

This information includes, but is not limited to, any records or facts about my medical condition, treatment, supplies, expenses, coverage or benefits, or my employment, vocation, education, training, or income, relating to my current disability or my ability to work, whether obtained prior to or after the date of this authorization ("Information").

Information may be provided to the following individuals or entities ("Benefit Managers"): the employer named above, Reed Group, their benefit plan or claims administrator(s), their related companies, contractors, investigators, attorneys, and service consultants, health care providers who treat or evaluate me with respect to my claim, and other individuals or entities involved in administering, evaluating, analyzing and managing the plan or my claim, to allow them to evaluate, analyze, manage and/or administer my claim for short term disability benefits, long term disability benefits, salary continuation, leave under the federal Family and Medical Leave Act, local and state leave laws, workers' compensation and/or any other health benefit program or leave benefit offered by and through my employer ("Benefits Program"), to support, defend, or review any determinations made with respect to the programs and benefits and to give my Information to any other person or entity if needed to find out whether I am eligible for benefits, to manage my claim under a Benefits Program, or to run a Benefits Program. The Benefits Managers will tell those receiving the Information that the Information is confidential.

I understand that once my Information is given out as authorized in this form, federal privacy laws may not protect it. Benefits Managers may give Information out again as described in this form.

I understand that this permission lasts twelve (12) months after my claim and all appeals are processed or twelve (12) months after the end of my coverage or benefits under the Benefits Program, whichever is longer, unless the law requires a shorter period. If I change my mind before that time, I can tell Reed Group in writing that I do not want Record Holders or Benefit Managers to share any more information. If I write to stop them from sharing Information, it will not change any actions they took before they receive my letter.

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Ralph R VanDeventer Jr. 9-29-08

Claimant's or Legal Representative's Signature Date

Legal Representative's Name (if any) Legal Representative's Relationship

The person or entity disclosing the Information is responsible for deciding whether to accept this authorization form and, on acceptance, shall send a copy to the claimant.

Please Fax to Reed Group at 518-880-6610 or return by mail in the enclosed business reply envelope

ReedGroup www.rgl.com

The Medical Disability Advisor

REIMBURSEMENT AGREEMENT
SHORT TERM DISABILITY PLAN

EMPLOYEE STATEMENT

Name:	Social Security Number:		Date of Birth:
Ralph Robert Van Deventer Jr.	[redacted]		11-19-58
Address - Street:	**City:**	**State:**	**Zip Code:**
965 Forge Lane	Toms River	NJ	08753
Home Telephone Number:	**Employee's Home E-mail Address** (if available):		
732-270-2897			

I am familiar with and understand the provisions of the Short Term Disability Plan for Eligible Employees of Johnson & Johnson and Affiliated Companies (the "Plan") that require that monthly payments to me will be reduced by certain amounts, such as state disability insurance (where applicable) and workers' compensation benefits. I understand that these reductions may sometimes be based on a reasonable estimate of the amount of other benefits that will be paid to me. I agree to these reductions.

I further understand and agree that I am required to repay Johnson & Johnson for any overpayments that have been made to me, including, without limitation, payments that have not been offset (or offset fully) for retroactive awards of state disability insurance, workers' compensation or other relevant benefits, as described under the terms of the Plan, and that I am required to pay the Plan any amounts that I recover from a third party in connection with my disability to the extent provided under the terms of the Plan. I agree to make these payments promptly, in accordance with the terms of the Plan. I understand and agree to the terms of the Plan regarding other rights of the Plan to recover amounts through subrogation and third party reimbursement.

I further agree to notify the Reed Group immediately upon my receiving notice that I have or will receive any amounts that offset my benefits under the Plan or any amounts that oblige me to pay or repay any amount to the Plan.

Employee's Signature:	Date:
Ralph R Van Deventer Jr	9/29/08
Witness Signature:	**Date:**
Maryann VanDeventer	9/29/08

Please Fax to 518-880-6610 or Mail to the Address Listed Above

ReedGroup www.rgl.net The Medical Disability Advisors

ATTENDING PHYSICIAN'S STATEMENT

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Patient's Full Name: Ralph Robert Van Deventer Sr. Date of birth: [redacted]

Date symptoms first appeared or accident happened?

Date patient first consulted you for this condition: 9-8-08

Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☒ No

If "Yes", please explain:

Is condition due to pregnancy? ☐ Yes ☐ No

If "Yes", expected date of delivery: _____

Primary Diagnosis: Tenosynovitis of Ankle Primary ICD Code (if available): 727.06

Secondary diagnosis: Lumbar Sprain Secondary ICD Code (if available): 847.2

Treatment Plan: detail the complete treatment plan (including therapy or referrals to other specialists):

Cam Walker for left ankle. Physical Therapy for back

State the surgical, obstetrical, or other diagnostic or therapeutic procedures requires, if any (Describe fully)

Procedure: _____

Date(s) Performed: _____ ☐ Inpatient ☐ Outpatient

Hospital Name: _____ Admission Date: _____ Discharge Date: _____

Medications: List all prescribed medications including Name, Dose, Frequency, and Start Date

Office Visits: Date of Last Visit 9-29-08 Date of Next Scheduled Visit: ~~10-13-08~~ 10-17-08

Functional Status: Has Patient been totally unable to work?

☒ Yes, From: 9-8-08 Through: _____

☐ No

What are the Functional Limitations that currently prevent the patient from working in any capacity?

Estimated Return to Work Date: 10/27/08

Modified Hours and/or duty date: _____

Full hours/duty date: _____

State any restrictions and/or accommodations which may be needed for modified duty and duration thereof:

Name of referring physician (if applicable): Referring physician's telephone number:

Address - Street: City: State: Zip Code:

Physician's full name/Specialty (please print): IRVING D. STROUSE, M.D., P.A. Physician's telephone number: 732-229-4333

Address - Street: 279 3rd Ave #504 City: Long Branch State: NJ Zip Code: 07740

Attending physician's signature: Date: 9/25/08

Reed Group | 15 Tech Valley Drive | 2nd Floor, Suite 3 | East Greenbush, New York 12061 | 866-829-8861 | Fax: 518-880-6610

State of New Jersey
PRESCRIPTION BLANK

IRVING D. STROUSE, M.D.
279 THIRD AVENUE, SUITE 504
LONG BRANCH, NJ 07740
(732) 229-4333 FAX (732) 571-1937

DEA #AS1444190 LIC #25MA 0226800
BATCH #HST080802000011 NPI #1184715963 SERIAL # 001033

IF PRESCRIPTION IS WRITTEN AT ALTERNATE PRACTICE SITE, CHECK HERE ☐
AND PRINT ALTERNATE ADDRESS AND TELEPHONE NUMBER ON REVERSE SIDE.

PATIENT Ralph Van Deventer DOB

ADDRESS DATE 9/25/08

Rx

Continue PT
3x wk for 3 wks

SUBSTITUTION PERMISSIBLE DO NOT SUBSTITUTE

DO NOT REFILL SIGNATURE OF PRESCRIBER

REFILL TIMES

Use separate form for each controlled substance prescription

TO UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM, FICTITIOUS ALTERATIONS OR FORGERY, ARE CRIMES PUNISHABLE BY

ReedGroup The Medical Disability Advisor

15 Tech Valley Drive
Suite 3, Second Floor
East Greenbush, NY 12061

September 19, 2008

Ralph R. Van Deventer Jr.
[redacted]

Case #: 74518
WWID#: 10900

Dear Ralph R. Van Deventer Jr.:

Johnson & Johnson has contracted with Reed Group to review and monitor Short Term Disability (STD) cases. Your disability case was referred to us for case management on 9/9/2008.

Based upon your diagnosis and/or additional medical documentation provided by your treating health care provider, the duration of your disability will be considered appropriate from 9/8/2008 to 10/5/2008. Reed Group will continue to review your claim on an ongoing basis to determine the potential for an earlier release to return to work, with or without temporary restrictions. Therefore, if it is determined by Reed Group that you can return to work, in any capacity, prior to the last authorized date of your disability as indicated in this letter you are expected to comply in order to continue receiving STD benefits.

Please be advised that Family Medical Leave (FMLA) and/or State Family Medical Leave (SFML) does run concurrent with this medical leave and has been authorized as follows:

09-08-2008 10-05-2008 Approved ------ FMLA

The requested leave will be applied toward your FMLA and/or SFML entitlement and is subject to review and/or recertification at a minimum of every thirty (30) days.

Should you require an extension or will not return to work on or before the end of the authorization period noted above, it is your responsibility to ensure that you and/or your health care provider submits supporting objective medical documentation to Reed Group five (5) days prior to the last authorized date of disability. This information will be reviewed for an extension of STD benefits. A few examples of this documentation are:

- Physician office/progress notes
- Diagnostic Test Results (X-rays, MRI, etc.)
- Laboratory Results
- Physical Therapy notes
- Medical clearance from disability

If you are returning to work on or before the end of the authorization period noted above, you will need to provide Reed Group with written documentation of your Release to Work from your health care provider prior to the last authorized date of disability. As a reminder, Reed Group must receive your return to work release and coordinate your return with the Company prior to your actual return to the worksite.

ReedGroup The Medical Disability Advisor

15 Tech Valley Drive
Suite 3, Second Floor
East Greenbush, NY 12061

In addition, it is also important to note that per the Company policy, if an employee does not return to work within three (3) business days of the end of the approved time off, the Company may determine that the employee has voluntarily resigned and consider the employee's employment to be terminated.

Please call Reed Group toll free at 866-829-8861 if you have any questions or concerns.

Thank you,

Cristina Teta
Reed Group

cc: J&J OHN
J&J Supervisor

Reed Group | 15 Tech Valley Drive | 2nd Floor, Suite 3 | East Greenbush, NY 12061| 866-829-8861 | Fax: 518-880-6610